General

Guideline Title

Quick starting contraception.

Bibliographic Source(s)

Clinical Effectiveness Unit. Quick starting contraception. London (UK): Faculty of Sexual and Reproductive Healthcare (FSRH); 2017 Apr. 32 p. [73 references]

Guideline Status

This is the current release of the guideline.

This guideline updates a previous version: Clinical Effectiveness Unit. Quick starting contraception. London (England): Faculty of Sexual and Reproductive Healthcare (FSRH); 2010 Sep. 12 p. [36 references]

This guideline meets NGC's 2013 (revised) inclusion criteria.

NEATS Assessment

National Guideline Clearinghouse (NGC) has assessed this guideline's adherence to standards of trustworthiness, derived from the Institute of Medicine's report Clinical Practice Guidelines We Can Trust.

 = Poor  = Fair  = Good  = Very Good  = Excellent

Assessment	Standard of Trustworthiness
YES	Disclosure of Guideline Funding Source
	Disclosure and Management of Financial Conflict of Interests
	Guideline Development Group Composition
YES	Multidisciplinary Group

YES	Methodologist Involvement
▮▮▮▮▯	Patient and Public Perspectives
	Use of a Systematic Review of Evidence
▮▮▮▮▮	Search Strategy
▮▮▮▮▮	Study Selection
▮▮▮▮▮	Synthesis of Evidence
	Evidence Foundations for and Rating Strength of Recommendations
▮▮▮▮▯	Grading the Quality or Strength of Evidence
▮▮▮▮▯	Benefits and Harms of Recommendations
▮▮▮▮▮	Evidence Summary Supporting Recommendations
▮▮▮▮▯	Rating the Strength of Recommendations
▮▮▮▮▮	**Specific and Unambiguous Articulation of Recommendations**
▮▮▮▮▮	**External Review**
▮▮▮▮▮	**Updating**

Recommendations

Major Recommendations

The recommendation grades (A-C, Good Practice Point [GPP]) are defined at the end of the "Major Recommendations" field.

Quick Starting if Pregnancy Can Be Excluded

Healthcare practitioners (HCPs) can offer quick start of any method of contraception at any time in the menstrual cycle if it is reasonably certain that a woman is not pregnant or at risk of pregnancy from recent unprotected sexual intercourse (UPSI). (GPP)

Quick Starting if Pregnancy Cannot Be Excluded

Women who have a negative high-sensitivity urine pregnancy test (HSUP) (able to detect human chorionic gonadotrophin [hCG] levels around 20 mIU/ml) but are at risk of pregnancy from recent UPSI should be advised that:

- Pregnancy cannot be excluded by an HSUP until ≥21 days after the last UPSI. (GPP)
- Emergency contraception (EC) may be indicated. (GPP)
- Combined hormonal contraception (CHC), progestogen-only pill (POP) and progestogen-only implant (IMP) can be quick started if they prefer not to delay starting contraception. Depot medroxyprogesterone acetate (DMPA) may be considered if other methods are not suitable or acceptable. (GPP)

The levonorgestrel intrauterine system should not generally be quick started unless pregnancy can be reasonably excluded. (GPP)
CHC containing cyproterone acetate should not be quick started unless pregnancy can be reasonably excluded. (GPP)
A copper intrauterine device can be quick started only if the indications for use as EC are met. (GPP)
After levonorgestrel EC (LNG-EC) administration, CHC, POP, IMP (and DMPA) can be quick started immediately. (Grade D)
After ulipristal acetate EC (UPA-EC) administration, they should wait 5 days before quick starting suitable hormonal contraception (CHC, POP, IMP [and DMPA]). (Grade D)
Additional contraceptive precautions (barrier or abstinence) are required until the quick started contraceptive method becomes effective. (GPP)
A follow-up HSUP is required no sooner than 21 days after the last UPSI. (GPP)

Use of Bridging Contraception

If a woman's choice of contraceptive method is not available or is not appropriate at the time of presentation, she should be offered a bridging method of contraception that can be quick started. (GPP)

Pregnancy Diagnosed After Quick Starting Contraception

The guideline development group advises that women should be informed that contraceptive hormones are not thought to cause harm to the fetus and they should not be advised to terminate pregnancy on the grounds of exposure. (GPP)

Women Using CHC, POP, IMP or DMPA

Women Who Wish to Continue the Pregnancy

If a pregnancy is diagnosed after starting contraception and the woman wishes to continue the pregnancy, the woman should be advised that the method should usually be removed or stopped. (GPP)

Women Who Choose Not to Continue the Pregnancy

If a pregnancy is diagnosed after starting CHC, POP, IMP or DMPA and the woman chooses therapeutic abortion:

A woman using IMP or DMPA can be advised to continue her method of contraception with no additional contraceptive precautions after abortion. (GPP)
A woman using CHC or POP can be advised to stop her method of contraception and restart contraception immediately after abortion with no additional contraceptive precautions. (GPP)
A woman using DMPA should be advised that there may be a slightly higher risk of continuing pregnancy (failed abortion) if DMPA is administered at the time of mifepristone administration. (Grade B)

Women Using IUC

HCPs should advise women whose intrauterine pregnancy is less than 12 weeks' gestation that intrauterine contraception (IUC) should be removed, as long as the threads are visible or it can be easily removed from the endocervical canal. This is regardless of whether the woman decides to continue with the pregnancy. (GPP)
HCPs should explain to women who have an intrauterine pregnancy with an IUC *in situ* that the risk of adverse pregnancy outcomes is greater than that for pregnancies without an IUC *in situ*. (Grade B)
HCPs should advise women who have an intrauterine pregnancy with an IUC *in situ* that removal of the IUC in the first trimester could improve pregnancy outcomes, but is associated with a small risk of miscarriage. (Grade B)

Definitions

Grading of Recommendations

A: At least one systematic review, meta-analysis or randomised controlled trial (RCT) rated as 1++, and directly applicable to the target population; *or* a systematic review of RCTs or a body of evidence consisting principally of studies rated as 1+, directly applicable to the target population and demonstrating overall consistency of results.

B: A body of evidence including studies rated as 2++ directly applicable to the target population and demonstrating overall consistency of results; *or* extrapolated evidence from studies rated as 1++ or 1+.

C: A body of evidence including studies rated as 2+ directly applicable to the target population and demonstrating overall consistency of results; *or* extrapolated evidence from studies rated as 2++.

D: Evidence level 3 or 4; or extrapolated evidence from studies rated as 2+.

Good Practice Point: Good Practice Points based on the clinical experience of the guideline development group.*

*On the occasion when the GDG finds there is an important practical point that they wish to emphasise but for which there is not, nor is there likely to be, any research evidence. This will typically be where some aspect of treatment is regarded as such sound clinical practice that nobody is likely to question it. It must be emphasised that these are NOT an alternative to evidence-based recommendations, and should only be used where there is no alternative means of highlighting the issue.

Clinical Algorithm(s)

None provided

Scope

Disease/Condition(s)

Unintended pregnancy

Guideline Category

Counseling

Evaluation

Management

Prevention

Risk Assessment

Clinical Specialty

Family Practice

Internal Medicine

Obstetrics and Gynecology

Preventive Medicine

Intended Users

Advanced Practice Nurses

Nurses

Physician Assistants

Physicians

Guideline Objective(s)

To recommend safe and appropriate clinical practice in relation to the provision of different contraceptive methods

Target Population

Women considering use of quick starting contraception as an option to prevent pregnancy

Interventions and Practices Considered

1. Assessment of risk of pregnancy
2. Use of quick start contraception or bridging contraception
    - Combined hormonal contraception (CHC)
    - Progestogen-only pill (POP)
    - Progestogen-only implant (IMP)
    - Depot medroxyprogesterone acetate (DMPA)
    - Levonorgestrel EC (LNG-EC)
    - Ulipristal acetate EC (UPA-EC)
    - Intrauterine contraception (levonorgestrel intrauterine system, copper intrauterine device)
3. Advise patients regarding stopping or removing contraceptive methods if pregnancy is diagnosed after quick starting contraception, whether the woman decides to continue with the pregnancy or proceed to termination of pregnancy

Major Outcomes Considered

- Rate of unintended pregnancy/emergency contraception failure rates
- Rate of initiation and continuation of contraception/uptake of long-term contraception
- Patient acceptability of the contraception method
- Adverse pregnancy or fetal outcomes (e.g., ectopic pregnancy, miscarriage, preterm birth, small for gestational age, abnormalities, premature rupture of membranes, fetal death)
- Disruption to menstrual bleeding patterns
- Lifespan of sperm in the genital tract
- Accuracy of estimated ovulation
- Pregnancy/ovulation/ovulation markers

Methodology

Methods Used to Collect/Select the Evidence

Hand-searches of Published Literature (Secondary Sources)

Searches of Electronic Databases

Description of Methods Used to Collect/Select the Evidence

Systematic Review of Evidence

A systematic review of the literature was conducted to identify evidence to answer the clinical questions formulated and agreed by the guideline development group (GDG). Searches were performed using relevant medical subject headings and free-text terms using the following databases: PubMed, EMBASE, Cochrane Central Register of Controlled Trials, Cochrane Database of Systematic Reviews, the Cumulative Index to Nursing and Allied Health Literature (CINAHL) and POPLINE®. Further, the National Guideline Clearinghouse (NGC) and Scottish Intercollegiate Guideline Network (SIGN) were also used to identify relevant guidelines produced by other organisations; these guidelines were checked to identify missing evidence. No language restrictions were applied to the searches.

Search Date

The databases were initially searched up to 28 November 2016. The evidence identified up to this point was used to develop the first draft of the guideline. Any evidence published after this date was not considered for inclusion.

Search Strategy

The literature search was performed separately for the different sub-categories covered in this clinical guideline. The search terms used are listed in Appendix 1 of the original guideline document.

Articles identified from the search were screened by title and abstract and full-text copies were obtained if the articles addressed the clinical questions relevant to the guideline. A full critical appraisal of each article was conducted. Studies that did not report relevant outcomes or were not relevant to the clinical questions were excluded.

Number of Source Documents

Studies included:

Populations, Intervention, Comparator, and Outcome (PICO) 1: 15
PICO 2: 17
PICO 3: 7
PICO 4: 19
PICO 4a: 2
PICO 4b: 8
PICO 4c: 7
PICO 4d: 26
PICO 5: 8
PICO 6: 16
PICO 7: 4
PICO 8: 8
PICO 9: 4
PICO 10: 22

Methods Used to Assess the Quality and Strength of the Evidence

Weighting According to a Rating Scheme (Scheme Given)

Rating Scheme for the Strength of the Evidence

Classification of Evidence Levels

1++: High-quality systematic reviews or meta-analysis of randomised controlled trials (RCTs) or RCTs with a very low risk of bias.

1+: Well-conducted systematic reviews or meta-analysis of RCTs or RCTs with a low risk of bias.

1-: Systematic reviews or meta-analysis of RCTs or RCTs with a high risk of bias.

2++: High-quality systematic reviews of case-control or cohort studies or high-quality case-control or cohort studies with a very low risk of confounding, bias or chance and a high probability that the relationship is causal.

2+: Well-conducted case-control or cohort studies with a low risk of confounding, bias or chance and a moderate probability that the relationship is causal.

2-: Case-control or cohort studies with a high risk of confounding, bias or chance and a significant risk that the relationship is not causal.

3: Non-analytical studies (e.g., case report, case series).

4: Expert opinions.

Methods Used to Analyze the Evidence

Review of Published Meta-Analyses

Systematic Review with Evidence Tables

Description of the Methods Used to Analyze the Evidence

The recommendations are graded (A, B, C, D and Good Practice Point) according to the level of evidence upon which they are based. The highest level of evidence that may be available depends on the type of clinical question asked. The Clinical Effectiveness Unit (CEU) adopts the comprehensive methodology developed by the Grading of Recommendations Assessment, Development and Evaluation (GRADE) (http://www.gradeworkinggroup.org/) to assess the strength of the evidence collated and for generating recommendations from evidence.

Methods Used to Formulate the Recommendations

Expert Consensus

Description of Methods Used to Formulate the Recommendations

Who Has Developed the Guideline?

Development of the guideline was led by the secretariat (Clinical Effectiveness Unit [CEU] staff) and involved the intended users of the guidelines (contraception providers) and patient/service user representatives as part of a multidisciplinary group. The scope of the guideline was informed by a scoping survey conducted amongst members of the Faculty of Sexual and Reproductive Healthcare (FSRH) and amongst service users from three sexual and reproductive health services across the United Kingdom (UK) (Sandyford [Glasgow], Scotland; Brook [Liverpool & Wirral and Milton Keynes], England; Aneurin Bevan University Health Board [Gwent], Wales). The first draft of the guideline was produced based on the final scope of the guideline agreed by the guideline development group (GDG). The first draft of the guideline (version 0.1) was reviewed by the GDG and a revised draft guideline (version 0.2) was produced in response to comments received.

Guideline Development Methodology

This FSRH guideline was developed in accordance with the standard methodology for developing FSRH clinical guidelines (outlined in the FSRH's *Framework for Clinical Guideline Development* [see the "Availability of Companion Documents" field). The methodology used in the development of this guideline has been accredited by the National Institute for Health and Care Excellence (NICE).

Considerations When Making Recommendations

FSRH clinical guidelines are produced primarily to recommend safe and appropriate clinical practice in relation to the provision of different contraceptive methods. Therefore, when formulating the recommendations, the GDG takes into consideration the health benefits, side effects and other risks associated with implementing the recommendations, based on the available evidence and expert opinion. Further, the GDG takes into consideration the different financial and organisational barriers that clinicians and services may face in the implementation of recommendations to ensure that the recommendations are realistic and achievable.

Reaching Consensus on the Recommendations

When further revisions based on public consultation feedback have been made, members of the GDG were asked to complete a form to indicate whether they agree or disagree with the recommendations proposed. The consensus process is as follows:

> Consensus will be reached when 80% of the GDG members agree with the recommendation.
> Recommendations where consensus is not reached will be redrafted in light of any feedback.
> The recommendation consensus form will be sent again for all recommendations. Consensus will be reached when 80% of the GDG members agree with the recommendation.
> If consensus is not reached on certain recommendations, these will be redrafted once more.
> If after one more round of consultation, consensus is still not reached, the recommendation will be taken to the CEC for final decision.
> Any group member who is not content with the decision can choose to have their disagreement noted within the guideline.

Rating Scheme for the Strength of the Recommendations

Grading of Recommendations

A: At least one systematic review, meta-analysis or randomised controlled trial (RCT) rated as 1++, and directly applicable to the target population; *or* a systematic review of RCTs or a body of evidence consisting principally of studies rated as 1+, directly applicable to the target population and demonstrating overall consistency of results.

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Good Practice Point: Good Practice Points based on the clinical experience of the guideline development group (GDG).*

*On the occasion when the GDG finds there is an important practical point that they wish to emphasise but for which there is not, nor is there likely to be, any research evidence. This will typically be where some aspect of treatment is regarded as such sound clinical practice that nobody is likely to question it. It must be emphasised that these are NOT an alternative to evidence-based recommendations, and should only be used where there is no alternative means of highlighting the issue.

Cost Analysis

A formal cost analysis was not performed and published cost analyses were not reviewed.

Method of Guideline Validation

External Peer Review

Internal Peer Review

Description of Method of Guideline Validation

The first draft of the guideline (version 0.1) was reviewed by the guideline development group (GDG) and a revised draft guideline (version 0.2) was produced in response to comments received, after which the it was sent to international and United Kingdom (UK)-based external independent reviewers suggested by the GDG at the face-to-face meeting. A further revision generated a version of the draft guideline (version 0.3) which was placed on the Faculty of Sexual and Reproductive Healthcare (FSRH) Web site for public consultation between 8 February and 7 March 2017. The revised draft guideline (version 0.4) was sent to the GDG for final comments and to reach consensus on the recommendations.

Evidence Supporting the Recommendations

Type of Evidence Supporting the Recommendations

The type of supporting evidence is identified and graded for each recommendation (see "Major Recommendations" field).

Benefits/Harms of Implementing the Guideline Recommendations

Potential Benefits

- Quick starting contraception, as opposed to waiting for the next menstrual period, could reduce a woman's risk of unintended pregnancy by facilitating immediate initiation of effective contraception.
- Quick starting could:
  - Reduce the time during which a woman is at risk of pregnancy. Women who have taken emergency contraception (EC) or who have irregular cycles could have an even longer wait until onset of their next menstrual period.
  - Prevent a woman from forgetting information on correct usage of her contraception. Avoid waning enthusiasm for the method and use of a less reliable alternative method.
  - Avoid costs of, and barriers to, returning for contraception (e.g., transport, time, childcare).
  - Reduce health care costs by reducing the number of appointments needed.

Potential Harms

- When quick starting contraception there will sometimes be a small risk that the woman is already pregnant or that emergency contraception (EC) will fail and she will conceive from recent unprotected sexual intercourse (UPSI). Diagnosis of pregnancy may be delayed if amenorrhoea is assumed to be due to the contraceptive method or if bleeding associated with the contraception is mistaken for a period. There are also theoretical concerns that hormonal contraception (HC) could be harmful to the fetus. See Section 4 in the original guideline document for additional information.

- A systematic review of observational studies found that women who conceived with an intrauterine device (IUD) *in situ* were at a greater risk of adverse pregnancy outcomes such as spontaneous abortion and preterm delivery compared with women who conceived without an IUD *in situ*.
- Because of the increased risks of adverse pregnancy outcomes (see Section 7.2 in the original guideline document) intrauterine contraception (IUC) should not be quick started unless pregnancy has been reasonably excluded or a woman meets the criteria for use of the copper (Cu) IUD for EC.
- Removal of IUC in the first trimester is thought to reduce the overall risk of adverse outcomes but is associated with a small risk of miscarriage.

Contraindications

Contraindications

It is illegal to knowingly insert intrauterine contraception (IUC) in a woman who is pregnant.

Refer to the *UK Medical Eligibility Criteria for Contraceptive Use (UKMEC)* for information about medical contraindications.

Qualifying Statements

Qualifying Statements

The recommendations included should be used to guide clinical practice but are not intended to serve alone as a standard of medical care or to replace clinical judgement in the management of individual cases.

Implementation of the Guideline

Description of Implementation Strategy

An implementation strategy was not provided.

Implementation Tools

Audit Criteria/Indicators

Staff Training/Competency Material

For information about availability, see the *Availability of Companion Documents* and *Patient Resources* fields below.

Institute of Medicine (IOM) National Healthcare Quality Report Categories

IOM Care Need

Staying Healthy

IOM Domain

Effectiveness

Patient-centeredness

Identifying Information and Availability

Bibliographic Source(s)

Clinical Effectiveness Unit. Quick starting contraception. London (UK): Faculty of Sexual and Reproductive Healthcare (FSRH); 2017 Apr. 32 p. [73 references]

Adaptation

Not applicable: The guideline was not adapted from another source.

Date Released

2017 Apr

Guideline Developer(s)

Faculty of Sexual and Reproductive Healthcare - Professional Association

Source(s) of Funding

The Faculty of Sexual and Reproductive Healthcare (FSRH) is a registered charitable organisation which funds the development of its own clinical guidelines. National Health Service (NHS) Lothian is contracted to host the Clinical Effectiveness Unit (CEU) in the Chalmers Centre and to provide the CEU's services using ring-fenced funding from the FSRH. No other external funding is received. Chalmers Centre supports the CEU in terms of accommodation, facilities, education, training and clinical advice for the members' enquiry service. As an organisation, NHS Lothian has no editorial influence over CEU guidelines, although staff members may be invited to join the CEU's multidisciplinary guideline development groups (GDGs), in an individual professional capacity.

Guideline Committee

Clinical Effectiveness Unit

Composition of Group That Authored the Guideline

Guideline Development Group

Secretariat: Dr Ailsa Gebbie, Director, Clinical Effectiveness Unit; Dr Sarah Hardman, Deputy Director, Clinical Effectiveness Unit; Mrs Valerie Warner, Researcher, Clinical Effectiveness Unit

Multidisciplinary Group: Dr Aisling Baird, Consultant in Sexual and Reproductive Healthcare (Abacus Community Sexual Health Service, Liverpool); Ms Alison Craig, Nurse Consultant in Sexual and Reproductive Healthcare (Chalmers Centre, NHS Lothian, Edinburgh); Dr Lynne Gilbert, Associate

Specialist in Sexual and Reproductive Healthcare (iCASH Cambridgeshire) and Vice Chair Clinical Standards Committee, FSRH; Dr Jennifer Heathcote, Associate Specialist (East Cheshire Centre for Sexual Health, Macclesfield); Dr Diana Mansour, Consultant in Community Gynaecology and Reproductive Healthcare, Head of Clinical Service, Sexual Health (Newcastle upon Tyne), FSRH Vice-President Clinical Quality; Dr Anatole S Menon-Johansson, Clinical Lead for Sexual & Reproductive Health (Guy's & St Thomas' NHS Foundation Trust, London); Dr Lucy Michie, Specialty Trainee in Community Sexual and Reproductive Health (Sandyford Sexual Health Service, Glasgow); Dr Sarah Millar, Community Sexual and Reproductive Health Trainee (Chalmers Centre, NHS Lothian, Edinburgh); Dr Priyanka Patel, Specialty Trainee in Community Sexual and Reproductive Health (Homerton Hospital, London); Mr Andrew Radley, Consultant in Public Health Pharmacy (NHS Tayside, Kings Cross Hospital, Dundee); Professor James Trussell, Senior Research Demographer (Princeton University, Princeton, NJ, USA), Honorary Fellow (Edinburgh University, Edinburgh)

Financial Disclosures/Conflicts of Interest

Declaration of Interests

Dr Baird received an honorarium from HRA Pharma for a presentation at their symposium at Current Choices 2013 entitled 'EC: is choice achievable?'. Dr Mansour has received financial support to attend pharmaceutical advisory board meetings, undertake research studies and speak at educational meetings and conferences along with travel grants from Aspen, Astellas, Bayer, Consilient Healthcare, HRA Pharma, Merck, Mithra, Pfizer and Vifor Pharma. Professor Gemzell-Danielsson serves on advisory boards and has been an invited speaker at scientific meetings for Bayer AG, MSD/Merck, HRA Pharma, Exelgyn, Actavis, NaturalCycles and Gedeon Richter on an ad hoc basis. Her institution has conducted studies sponsored by HRA Pharma, Mithra, Bayer and MSD/Merck. None of the individuals involved had competing interests that prevented their active participation in the development of this guideline.

Guideline Status

This is the current release of the guideline.

This guideline updates a previous version: Clinical Effectiveness Unit. Quick starting contraception. London (England): Faculty of Sexual and Reproductive Healthcare (FSRH); 2010 Sep. 12 p. [36 references]

This guideline meets NGC's 2013 (revised) inclusion criteria.

Guideline Availability

Available from the Faculty of Sexual and Reproductive Healthcare Web site .

Availability of Companion Documents

The following is available:

> Clinical Effectiveness Unit. Framework for developing clinical guidelines. London (UK): Faculty of Sexual and Reproductive Healthcare (FSRH); 2016 Oct. 15 p. Available from the Faculty of Sexual and Reproductive Healthcare (FSRH) Web site .

Questions for continuing professional development and auditable outcomes are available in the original guideline document .

Patient Resources

None available

NGC Status

This NGC summary was completed by ECRI Institute on March 7, 2011. This summary was updated by ECRI Institute on December 4, 2017. The guideline developer agreed to not review the content.

This NEATS assessment was completed by ECRI Institute on October 25, 2017. The guideline developer agreed to not review the content.

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